RHODE ISLAND DEPARTMENT OF HEALTH
Instructions for Consumer Documents

The following documents must be made available to consumers by Health Plans:

The Consumer's Guide To Health Plans In Rhode Island*
The Consumer's Right To Know About Health Plans In Rhode Island*
The Provider Directory, which must be updated annually.
*does not apply to Medicare and Medicaid health plans

Each of these documents must conform to the following technical specifications:

- Consumers must be notified annually of the availability of these documents.
- All three documents must be included on the Health Plan Website. OR
- A hyperlink can be provided to the Department of Health Website for the Consumer's Guide.
- Hard copies are to be made available to consumers upon request.
- The Health Plans' Customer Service staff must inform members of the availability of these documents on the Health Plans' Website and that hard copies are available upon request.

Consumer Disclosure Documents:

The Consumer's Right To Know About Health Plans In Rhode Island Consumer Disclosure shall be prepared using black type. Type font must be Arial, 12 point, or its equivalent. The Covered Services at a Glance section must be Arial, 10 point.

The text in each question must remain exactly as is. Using the available space in the answer boxes, the Health Plan must provide an answer to each question.

The cover page includes the title and subtitle of the document *Consumer's Right to Know About Health Plans in Rhode Island*, and must be used exactly (including graphic design). The Health Plan may insert its logo in the space between "Rhode Island" and "Consumer Disclosure" (total area approximately 3.5 inches). Each Health Plan must also include its unique, legal name and the date on which the disclosure is effective (month, day, year -- e.g. March 10, 2000) in the space provided. This information must be of a size and style so as to be clearly legible to consumers, leaving reasonable margins on every side.

On the next page, the title and headings and text must be used exactly. The Health Plan may insert its logo in the area provided. The unique, legal name of the Health Plan and the date [month, day, year] on which the disclosure is effective [accurately discloses Health Plan information and is approved by the Rhode Island Department of Health (Department)] must be entered at the designated places. The first three paragraphs explain the Health Plan law, the regulatory environment, and the purpose of the disclosure.

Who can I contact at the Health Plan for information? This page informs consumers about how to contact Health Plan representatives concerning general questions. In the text box, Health Plans must substitute actual titles, addresses, phone and fax numbers, TDD, email address, and web address of the plan representative(s) who are responsible for responding to consumer inquiries for general information. Plans must use the Spanish language text about how to contact a Spanish speaking representative. The Spanish language contact must be fluent in Spanish, knowledgeable about the Health Plan and capable of responding to questions involving general information about the plan.

> Title of Health Plan Representative
> Address of Health Plan
> Toll-free 1-800-xxx-xxxx *Telephone 401-xxx-xxxx Fax: 401-xxx-xxxx
> TDD Number 401-xxx-xxxx Email: healthplan@internet.org Web address:
> _____
> Para contactor a un representante que hable Espanol, llame a:
> Nombre del Representante del Plan 1-800-xxx-xxxx

* Required elements in contact information

How does the Health Plan review and approve covered services? The Health Plan must give a summary of its review requirements and procedures for determining medical necessity including pre-authorization, concurrent, post-service, and retrospective review, as appropriate, and the information concerning the criteria used to authorize treatments and procedures.

> Example: The ABC Health Plan pays only for covered services that are medically necessary. Some covered services (such as non-emergency hospitalization) always require a review by the Plan before they will be paid for. Other covered services which are recommended by participating providers may be reviewed by the Plan as they occur or after they occur to make sure they are medically necessary. The criteria for medical necessity include that the services are essential, are appropriate for your condition, meet general medical standards and are provided at the correct level, time and setting. Written policies and criteria for approving general and specific services are available from the Customer Services Specialist.

What if I have an emergency? The definition of "emergency" is consistent with the standardized definitions. The Health Plan must summarize the criteria, procedures and coverage/payment policies for obtaining emergency care services, including out-of-state or out-of-area emergencies. This must include pre-authorization requirements, and whether the plan will pay for exams to determine if emergency health care services are necessary, actual emergency services, and services following emergency treatment or stabilization.

Example: The ABC Health Plan covers hospital emergency room examinations to determine if emergency services are necessary, emergency services, and any necessary covered services following emergency treatment--including out-of-state or out-of-area emergencies. These services are subject to a $25 co-pay if no hospital admission results. To be certain about coverage, members should call 401-555-5555 as soon as possible (but within 12 hours) to speak with the Emergency Care Coordinator.
Example: Single Service Plans: State policy and emergency.

What if I refuse referral to a participating provider? The Health Plan must summarize its policy to direct enrollees to particular providers and any limitations on payment if the enrollee refuses the referral and obtains a recommended service from a non-participating provider.

Example: Providers in the ABC Health Plan belong to established networks to make referrals between general and specialist providers easy and effective. If you prefer a particular specialist, please discuss this with your provider to find out if he/she is part of the provider network and if a referral is possible. If you decide to use a non-participating provider, you may have to pay the full cost of those health care services.

Does the Health Plan require that I get a second opinion for any services? What if I want a second opinion? The Health Plan must disclose a summary of its policies and procedures on access to a second opinion, including any services for which the plan requires a second opinion, the policy on a second opinion if the consumer wants one, and any related reimbursement policies.

Example: This plan does not require you to get a second opinion before it will pay for any covered benefits. This plan will pay, at least in part, for a second opinion even if you request one. You may be required to pay part of the cost, generally $25 or 50% of the cost, whichever is less.

How does the Health Plan make sure that my personal health information is protected and kept confidential? The Health Plan must give a summary of its policy on confidentiality including measures taken by the plan to ensure confidentiality of the individual's health care record, including information obtained by contracted organizations (e.g. UR agents). These measures must meet all applicable state and federal laws.

How am I protected from discrimination? The Health Plan must give a summary of its policy on protection from discrimination which meets all applicable state and federal laws.

If I refuse treatment, will it affect my future treatment? The Health Plan must state whether enrollees have a right to refuse treatment and must provide a summary of its policies on treatment refusals and any effects refusal may have on access to future treatment, Health Plan coverage or payment for future services.

How does the Health Plan pay providers? The Health Plan must disclose the nature of its financial arrangements with health care providers. The "disclosure" statements are prescribed by law and regulation and must be used exactly. The Health Plan must insert the one statement from among the following three which best describes its financial arrangement with providers into the designated space.

> "This health plan uses capitated arrangements with its providers or contains other similar risk sharing arrangements."
>
> "This health plan may include a capitated reimbursement arrangement or other similar risk sharing arrangement and other financial arrangements with your provider."
>
> "This health plan is not capitated and does not contain other risk sharing arrangements."

In choosing the most appropriate statement, Health Plans must consult the standardized definitions of "capitation" and "risk sharing", as well as any other term which may be applicable to their choice to ensure that this disclosure is consistent across all plans.

How is coverage renewed or canceled? The Health Plan must insert a summary statement of its policies and procedures for renewing and canceling coverage. This includes the timing of renewal (policy anniversary date), the possibility of premium increases and conditions under which coverage may be cancelled.

> Example: The ABC Health Plan will renew your coverage on its calendar anniversary date [mmddyy] unless you choose another plan offered by your employer. Some provisions may change, including out-of-pocket costs. Your coverage may only be cancelled if your employer fails to pay the premiums for your group.

If I am covered by two or more health plans, what should I do? The Health Plan should describe its policies on any information which members are expected to provide to assist the plan with coordination of benefits.

Covered Services At A Glance (CSAG)

The types of service, order of presentation, headings and format of this disclosure must be used exactly.

The purpose of the CSAG is to summarize the benefits available under a specific Health Plan and to facilitate comparison of plans and alert enrollees to items of special interest. The objective here is to provide information that most consumers will find useful, focusing on questions most asked, arrangements that are typically confusing and/or clarifying most important features of a plan (especially those that are often misunderstood). It is expected that consumers will contact a plan representative or consult the Official Plan Documents for the most detailed information.

Name of Health Plan: Replace this with the plan's unique, legal title as given on the first page.

Annual Deductible: The annual deductible ($ amount) for both individual and family members of this plan must be included.

Maximum Lifetime Cap: The maximum lifetime cap ($ amount) for both individual and family members of this plan must be included.

Type of Service: The categories of services are the same for all plans and must be used exactly, including the order of presentation and placement on the page. Not all types and/or subtypes of services are included in this general summary. Items on this list are not exhaustive or necessarily mutually exclusive. They represent commonly recognized categories of health care services in which consumers may have general interest as it pertains to their covered benefits. If a service (or a related service) is not covered, this should be indicated in the "limitations" column. Differences arising from subdivisions of a service (e.g. Eye Care: examinations and eyewear or Nursing Home: skilled and unskilled) should be handled in the out-of-pocket and/or limitations column, as appropriate. If the benefit is covered only under an individual rider, the plan should indicate "Rider only" in the limitations column.

Is prior authorization required? The objective is to alert the enrollee to a covered service, which typically requires prior authorization with respect to payment. Prior authorization does not mean solely the recommendation of a service by a participating (or primary care) provider, but must include review by another plan representative before payment is authorized.

A participating provider recommends a covered service. If pre-authorization review is typically required (or always required) before that service will be paid for by the Health Plan, then insert "yes". General specifications and/or exceptions may be noted in the remaining columns. Insert "no" if prior authorization is never required for that service.

What out of pocket expenses will I have to pay? The objective is to alert the enrollee to covered services for which s/he may have to pay out-of-pocket costs. The annual

deductible is already indicated on the header column and need not be repeated for each service.

Responses in this column are limited to the following format:

None, plan pays 100%	
___% Coinsurance	example: 20% Coinsurance
___% to ___ % Coinsurance	example: 10% to 20% Coinsurance
___ % after deductible	example: 20% Coinsurance after deductible
$ ___ Actual Co-pay	example: $10 Co-pay
$ (Min.) to $ (Max.) Co-pay	example: $5 to $15 Co-pay (Multi product lines in one plan)
Note: $____ or ___%	example: Eyewear: $50 or 100%
Note: Other expenses may apply	example: Specialists paid in full

What other limitations apply? The objective is to alert the enrollee to covered services which have limitations, restrictions and/or exclusions not previously described under columns describing covered services, prior-authorization or out-of-pocket expenses. The emphasis here is on typical or most commonly encountered limitations with a significant impact on services.

Responses in this column are limited to the following format.

None	No other limitations, restrictions or exclusions
(#) visits annual/lifetime	example: 12 visits annual/30 visits lifetime
(#) days annual/lifetime	example: 30 days annual/100 days lifetime
(#) treatments annual/lifetime	example: 20 treatments annual
$ ___ annual/lifetime maximum	example: $1500 annual maximum
(Service) not covered	example: Air ambulance not covered
Other free narrative	example: Semiprivate room only Call for information
Special requirement	example: Rider Only Skilled Nursing only Open/Closed Formulary

In the event that multiple and significant limitations, restrictions and exclusions apply to a single Type of Service, the Health Plan must insert the following:

“Multiple restrictions apply; call the Health Plan or consult the official plan documents.”

If I choose a non-participating provider, will the service be covered? The objective is to alert enrollees to situations in which Health Plans will not cover services obtained from non-participating providers or may require "extra" payments in addition to regular co-pays and/or coinsurance. .

Health Plan may choose from the following responses:

Yes, with no additional payments
Yes, with additional payment of $____ or ___%
Yes, (free text)
No, not covered